SWAT Surgical Associates, L.L.P.

3509 22nd Street
Lubbock, Texas 79410

806.799.SWAT Tel
806.788.8500 Fax

Patient Health History Questionnaire
BARIATRIC SURGERY

The information requested in this questionnaire is very important. To give you the best care, and to obtain your insurance approval, we must have complete answers. Please be thorough.

_____ /_____ /_____ DATE: _____ /_____ /_____
PATIENT: LAST NAME FIRST MIDDLE

_____ /_____ /_____ _____ _____ /_____ /_____
BIRTH DATE AGE SOCIAL SECURITY NO.

_____ _____
HOME PHONE NO. CELL PHONE NO.

Ht: _____ Current Weight: _____

WEIGHT RELATED ILLNESSES

Have you had, or do you have, any of the following illnesses or symptoms?

CARDIOVASCULAR DISEASE:

Yes □ No □	Palpitations (irregular and/or forceful heartbeat)	
Yes □ No □	Varicose Veins	
Yes □ No □	Swelling of Ankles/Feet	
Yes □ No □	Blood clot (Deep Vein Thrombosis- DVT)	
Yes □ No □	Pulmonary Embolism	
Yes □ No □	High Cholesterol	
Yes □ No □	High Triglycerides	
Yes □ No □	High Blood Pressure	
Yes □ No □	Angina (chest pain)	
Yes □ No □	M.I. (myocardial infarction, heart attack)	
Yes □ No □	CABG (coronary artery bypass graft, known as open heart surgery)	
Yes □ No □	Abnormal EKG	
Yes □ No □	Shortness of breath	
Yes □ No □	Stress test to rule out cardiac problems	Date:_____
Yes □ No □	Echocardiogram (heart ultrasound)	Date:_____

DIABETES:

Yes □ No □	Diabetes
Yes □ No □	Do you take Insulin
Yes □ No □	Oral Medication

ASTHMA

Yes □ No □ Asthma

Yes □ No □ Hospitalization in last 2 years

Yes □ No □ Steroid use in last 2 years

SLEEP APNEA SYNDROME

Yes □ No □ Sleep Apnea

Yes □ No □ CPAP or BiPAP

Year diagnosed: _____

Last sleep study: _____

Yes □ No □ **HEARTBURN/ HIATUS HERNIA**

GALLBLADDER

Yes □ No □ Gallbladder disease

Yes □ No □ Gallbladder removed

Yes □ No □ Ultrasound performed

GENITO-URINARY:

Yes □ No □ Leakage of urine with laughing/coughing/ sneezing

Yes □ No □ Wear pads frequently

MUSCULOSKELETAL:

Yes □ No □ Arthritis

Yes □ No □ Low back strain/pain/sciatica

Yes □ No □ Pain in hips/knees/ankles/feet

Yes □ No □ Assistance to ambulate

Exercise limitation: (CIRCLE ONE) None / Minimal / Severe

Yes □ No □ **CANCER**

Yes □ No □ Breast

Yes □ No □ Endometrial

Yes □ No □ Uterine

Yes □ No □ Prostrate

Other: _____

Treatment:_____

Remission:_____

Yes □ No □ **WEIGHT RELATED INJURIES AND TRAUMA**

Yes □ No □ **VENOUS STASIS DISEASE**

Yes □ No □ **COLITIS**

Yes □ No □ **LIVER DISEASE**

Yes □ No □ **ULCERS / GASTRITIS**

Yes □ No □ **RECTAL BLEEDING**

Yes □ No □ **THYROID DISEASE**

Yes □ No □ **EATING DISORDER**

If Yes, have you been seen by a specialist? Yes □ No □

PAST MEDICAL HISTORY

Please identify which of the following childhood illnesses and operations you have experienced.

□ Rheumatic fever Year:_____ □ Heart murmur Year:_____

□ Obesity Year:_____ □ Bleeding disorders Year:_____

□ Bleeding disorders Year:_____ □ Appendectomy Year:_____

□ Asthma Year:_____ □ Tonsillectomy Year:_____

For female patients only

Currently pregnant: Yes □ No □

Number of pregnancies: _____ Age at first period: _____

Number of live births: _____ Date of last period: _____

Miscarriages/abortions: _____

Obstetric complications:

_____

_____

Do you presently use:

□ Birth control pills Yes □ No □ List Type: _____

□ Estrogens Yes □ No □ List Type: _____

Please list below all serious illnesses and hospitalizations you have experienced in adulthood.

Major Illness **Date** **Treatment**

_____

_____

_____

_____

Major Surgery

_____Year_____

_____Year_____

_____Year_____

Allergy to surgical tape/latex **Yes □ No □**

Drug Allergies **Drug** **Reaction** _____√ **Here if NONE**

_____

_____

Current Medications:

Drug	Dosage	Frequency	Reason Prescribed

Aspirin Yes □ No □

Non-Steroidal Anti-Inflammatory Drug (NSAID) Yes □ No □

Blood Thinner (Coumadin, Plavix, Lovenox) Yes □ No □

SYSTEM REVIEW

Check all symptoms which you have, or have had. Write in any additional problems.

HEAD, EYE, EAR, NOSE & THROAT:

□ STUFFY NOSE	□ RUNNY NOSE	□ HAY FEVER
□ SINUS TROUBLE	□ EARACHE	□ HEADACHE
□ BLURRY VISION	□ DOUBLE VISION	□ HALOS AROUND LIGHTS
□ LOSS OF NIGHT VISION	□ BUZZING IN EARS	□ RINGING IN EARS
□ DISCHARGE FROM EAR	□ LOSS OF HEARING	□ DIZZINESS
□ VERTIGO	□ LOSS OF BALANCE	□ SORE THROAT
□ LUMP IN THROAT	□ TROUBLE SWALLOWING	□ HOARSENESS
□ PAIN WITH SWALLOWING		

RESPIRATORY:

□ BRONCHITIS	□ WHEEZING	□ ASTHMA
□ USE TWO PILLOWS	□ BLOOD IN SPUTUM	□ OUT OF BREATH WITH EXERTION
□ COUGH	□ EMPHYSEMA	□ SHORTNESS OF BREATH AT NIGHT
□ WAKE UP AT NIGHT COUGHING OR CHOKING		□ WAKE UP AT NIGHT SHORT OF BREATH

CARDIOVASCULAR:

□ PALPITATIONS	□ POUNDING OF HEART	□ SKIPPING OF HEARTBEAT
□ PAINS IN CHEST	□ PAINS IN NECK	□ PAINS IN ARMS
□ HEART ATTACK	□ HEART MURMUR	□ SQUEEZING OF CHEST
□ COLD FEET	□ LOSS OF PULSES	□ ABNORMAL ELECTROCARDIOGRAM
□ IRREGULAR HEARTBEAT	□ HIGH BLOOD PRESSURE	□ PAIN IN LEGS
□ BLUE TOES	□ BLUE FINGER	

GASTROINTESTINAL:

□ HEARTBURN	□ NAUSEA	□ VOMITING
□ GASSINESS	□ ACID STOMACH	□ DIARRHEA
□ CONSTIPATION	□ HEMORRHOIDS	□ BELCHING FLUID IN THROAT
□ BURNING IN THROAT	□ PAINS IN STOMACH	□ FOOD STICKING IN CHEST
□ BURNING IN STOMACH	□ BLOOD IN STOOLS	□ PAIN WITH BOWEL MOVEMENT
□ FISSURES	□ CRAMPS	□ IRRITABLE COLON COLITIS

GENITOURINARY:

□ PAIN WITH URINATION	□ TROUBLE STARTING URINE	□TROUBLE STOPPING URINE
□ SMALL URINE STREAM	□ BLOOD IN URINE	□ KIDNEY FAILURE
□ NEPHRITIS	□ FREQUENT URINATION	□ URINARY TRACT INFECTIONS
□ KIDNEY STONES	□ GETTING UP AT NIGHT TO URINATE	
□ LEAKAGE OF URINE WITH COUGH OR SNEEZE		

MEN:

□ DISCHARGE FROM PENIS □ LOSS OF ERECTION □ PAINFUL ERECTION

OB/GYN:

□ VAGINAL DISCHARGE □ VAGINAL BLEEDING

□ PAIN WITH INTERCOURSE □ IRREGULAR PERIODS

ENDOCRINE (GLANDULAR):

□ LOW THYROID □ HYPERTHYROID □ GOITER

□ GRAVE'S DISEASE □ THYROID NODULES

□ DIABETES □ ADRENAL GLAND TUMOR □ FREQUENT FLUSHING

□ FREQUENT HEAVY SWEATING

MUSCULOSKELETAL:

□ PAIN IN JOINTS □ SWELLING OF JOINTS □ WARM JOINTS

□ FLUID IN JOINTS □ ARTHRITIS □ BROKEN BONES

□ SPRAINS □ LOW BACK PAIN □ SCIATICA

□ HIP PAIN □ KNEE PAIN □ ANKLE PAIN

□ FOOT PAIN □ FLATFEET □ SLIPPED DISK

□ HERNIATED DISK □ REDNESS OF SKIN OVER JOINTS

NEUROLOGICAL:

□ DIZZINESS □ VERTIGO □ FALLING TO THE SIDE

□ FALLING AT NIGHT □ NUMBNESS □ TINGLING

□ SHAKINESS □ PINS & NEEDLES FEELINGS □ WEAKNESS OF ANY MUSCLES

□ TWITCHING OF MUSCLES □ WEAKNESS OF GRIP □ TREMOR

□ FAINTING □ CONVULSIONS □ FITS

□ LOSS OF CONSCIOUSNESS

PSYCHOLOGICAL:

□ NERVOUSNESS □ DEPRESSION

□ PSYCHOLOGICAL COUNSELING □ THOUGHTS OF SUICIDE

□ SUICIDE ATTEMPTS □ PSYCHIATRIC TREATMENT

□ HOSPITALIZATIONS FOR EMOTIONAL PROBLEM □ANXIETY

FAMILY HISTORY

Family Member	Living?	Age	Age at Demise	Illness/Cause of death	Ht	Wt
Mother						
Father						
Maternal Grandmother						
Maternal Grandfather						
Fraternal Grandmother						
Fraternal Grandfather						
Sibling						
Sibling						
Sibling						
Sibling						

Please indicate if there is a family history of:

- □ Obesity
- □ Diabetes
- □ High blood pressure
- □ Heart disease
- □ High blood cholesterol
- □ Lung disease, asthma or emphysema
- □ Kidney disease
- □ Bleeding tendency or blood disorder
- □ Breast cancer
- □ Colon cancer

Please list all the physicians whose care you are under.

	Name	Location	Telephone
Primary Care / Internist Physician			
Gynecologist			
Orthopedist			
Psychiatrist/Psychologist			
Physical Therapist			
Other			

SOCIAL HISTORY

Marital Status: S: ___ M: ____ D: ____ W: ____ Religion: _____

Level of Education: _____

Persons Living in the Home:_____

Smoking History: Never □ Former Smoker □ Year Quit: _____

CURRENTLY Smoking: Yes □ No □

Number of packs per day:_____ Number of years:_____

Are you willing to quit? Yes □ No □

Recreational Drug Use: Yes □ No □ Describe:_____

Alcohol Intake Yes □ No □

Frequency of alcoholic beverages: None □ Light □ Moderate □ Heavy □

WEIGHT HISTORY

Please estimate as closely as possible for all that applies.

Life Event	Age	Weight
Birth Weight		
Start of High School		
High School Graduation		
Marriage		
Lowest Weight in Past 5 Years		
Highest Weight in Past 5 Years		
1st Pregnancy		
Last Pregnancy		

Please list any food allergies or intolerances you may have:

_____

_____

_____

_____

Weight Loss Attempts

Method	Yes	# Months	Year	# of Pounds Lost	Wt Regained
Weight Watchers					
Jenny Craig					
Nutri-Systems					
Opti/Medi Fast					
Phen Fen/Redux					
Phentarmine					
Meridia					
Xenical / Orlistat					
Ephedra					
Metabolife					
Nutritionist					
Slim Fast					
Atkins					
South Beach					
Overeaters Anonymous					
Weight Loss Camp					
Medically Supervised Wt Loss					
Doctor Prescribed Diet					
Hypnosis					
Acupuncture					
List any other wt loss attempt(s)					

Previous weight loss surgery **Yes □ No □**

Date of Surgery: _____ Name of Surgeon: _____

Name of operation: _____ Wt at Operation: _____ Max Amt Wt Lost: _____

Please list any other information you feel is important for your surgeon:

_____

_____

_____

The above information is true to the best of my knowledge:

Print Patient Name: _____ ***Patient Signature:*** _____

Date: _____

Surgeon: _____ ***Date Reviewed with Patient:*** _____

Surgeon Signature: _____

NUTRITIONAL HISTORY

Name: _____ Age: _____ DOB: _____

Occupation: _____

Ht:_____ Wt: _____ BMI: _____ IBW: _____

What were the 2 most effective diets and why? **1,** _____ **2.** _____ **Why:** _____
Have you seen a nutritionist in the past? Yes □ No □
What is the most weight lost on a diet? _____ **How?** _____

Exercise History
Please list exercise level below:

	Describe	Frequency	Duration	Time
□ None				
□Moderate				
□ Average				
□ Strong				

FOOD PREFERENCES

Indicate which foods you prefer (which foods would most likely make you go off a diet).

Rank each selection from **1 - like very much** to **4 - can take it or leave it**

Candy ____	Chips/Snacks ____	Seafood ____
Chocolate ____	Fried Food ____	Dairy ____
Cakes/Pies ____	Fast Food ____	Red Meat ____
Cookies ____	Pizza ____	Poultry ____
Ice Cream ____	Bread/rice/pasta ____	Vegetables ____
	Cold Cereal ____	Fruit ____

Cravings/ Favorite Foods:

_____

_____

_____

_____

FOOD PATTERN: Number of meals per day: _____ Eat between meals: Yes □ No □

TYPICAL DIET – when NOT dieting- Current?: Yes/NO

**Include time, amount, brand, condiments added (sugar/cream/ mayo etc), beverages.*

Breakfast-time:	Snack Time:	Lunch Time:	Snack Time:	Dinner Time:	Snacks Time:
				__2nd/3rd helping?	

TYPICAL DIET- while dieting- Current? Yes/ NO

Breakfast Time:	Snack Time:	Lunch Time:	Snack Time:	Dinner Time:	Snacks Time:

.

Circle & add others where appropriate:

Beverages *#/day*: water ___, coffee/tea ___, soda___, diet soda ___, fruit juice ____, alcohol ___, milk ___, sport drinks ___, flavored coffees ____, smoothies ____

Dairy foods: *low-fat or whole milk-* cottage cheese, milk, yogurt, cheese

Protein foods: poultry, fish, seafood, beef, pork/ pork products, eggs, burgers, veggie/soy burgers/meats, peanut butter, beans

Starches/Grains: *whole grain wheat/oat or white-* bread, rolls, English Muffin, bagels, rice, pasta, cereal name _____, Pancakes, waffles, French toast, muffins, breakfast pastry, hot cereal, bialy

Fat added to food: cream, butter; oil, salad dressing, mayonnaise, PAM, butter substitute, sugar/ sugar sub, creamy soups or sauces

Vegetable: ___ *d/wk*: broccoli/cauliflower, spinach/green leafy; salads; string beans; corn; peas/ carrots; squash; potatoes/ French fries/ mashed potato; yams; plantains

Fruits: ___ *d/wk*: Tropical fruit, seasonal fruit, banana, berries, apples, oranges, grapefruit, grapes, melon

Sweet snacks/ Desserts: ice cream, cookies, chocolate candy, gummy/hard candy, pastry, cakes, pie

Salty/crunch snacks: nuts, seeds, crackers and cheese, chips, pretzels, popcorn

Fast Food/ Restaurants:_____ *#/wk:* Give an example of a typical meal if you order from:

Chinese/Asian cuisine:
Spanish/ Mexican:
French/Italian/ Pizza:
Steakhouse/seafood:
American/Diner/ Deli/ Cafeteria:
McDonalds/Burger King/Wendy's:
Other:

Binges/ Trigger foods/ Environmental triggers:

Eating habit & emotional eating self- assessment:

		Eat in response to:
__ Skip meals/ erratic meal times	__ Dine Out > 2x per week	__ Depression
__ Secret eating	__ Large Portions	__ Anger
__ Binge eating (feel out of control/guilt)	__ Frequent Snacks/ grazing	__ Habit/ "Time to eat"
__ Night eating	__ Eat until stuffed/ uncomfortable	__ Bored/ "because its there"
__ Eat while doing/ TV/ cooking/ work	__ Usually hungry at meals/ snacks	__ Lonely
__ Eat fast/ don't chew well	__ Rarely hungry at meals/ snacks	__ Worried/ stressed/ anxious/ nervous
__ Clean plate	__ Not satisfied after meals- still hungry	__ Reward/ celebratory
__ 2nd helpings often	__ Sweets/ baked goods	__ Relaxation/ Escape
__ Meal Eater	__ Salty, crunchy snacks	__ Hunger
__Grazer/snacker btw/ @ meals	__ Savory meals/ foods	__ Craving w/o hunger

What do you feel are your personal diet and behavioral obstacles for losing weight and maintaining weight loss: _____

How much weight would you like to lose from WLS? What do you feel is your ideal weight?

_____ _____

Diet and Behavioral Self Recommendations:

1. Read food labels/ practice portion control
2. Make lower fat choices: Avoid fried/fast foods- alt. cooking methods/ food choices
3. Avoid beverages with calories and carbonation; reduce caffeine intake
4. Exercise 30 minutes brisk walking most days of the week
5. Time management and meal planning
6. Avoid bringing trigger/ binge foods into the home or workplace
7. Other: _____

The above information is true to the best of my knowledge. Print Patient Name: _____

Patient Signature: _____ Date: _____

Nutritionist: _____ Date Reviewed with Patient: _____

Nutritionist Signature: _____